

Department of Health and Human Services
Public Health Services
Grant Progress Report

Review Group	Type	Activity	Grant Number
Total Project Period		Through:	
From:			
Requested Budget Period:		Through:	
From:			

1. TITLE OF PROJECT

2a. PRINCIPAL INVESTIGATOR OR PROGRAM DIRECTOR
(Name and address, street, city, state, zip code)3. APPLICANT ORGANIZATION
(Name and address, street, city, state, zip code)

2b. E-MAIL ADDRESS

4. ENTITY IDENTIFICATION NUMBER

2c. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT

5. TITLE AND ADDRESS OF ADMINISTRATIVE OFFICIAL

2d. MAJOR SUBDIVISION

E-MAIL:

6. HUMAN SUBJECTS

<input type="checkbox"/> No <input type="checkbox"/> Yes	6a. Research Exempt <input type="checkbox"/> No <input type="checkbox"/> Yes	6b. Human Subjects Assurance No.
If Exempt ("Yes" in 6a): Exemption No.		6c. NIH-Defined Phase III Clinical Trial <input type="checkbox"/> No <input type="checkbox"/> Yes
If Not Exempt ("No" in 6a): IRB approval date		<input type="checkbox"/> Full IRB or <input type="checkbox"/> Expedited Review

7. VERTEBRATE ANIMALS

<input type="checkbox"/> No <input type="checkbox"/> Yes	7a. If "Yes," IACUC approval Date
7b. Animal Welfare Assurance No.	

8. COSTS REQUESTED FOR NEXT BUDGET PERIOD

8a. DIRECT \$

8b. TOTAL \$

9. INVENTIONS AND PATENTS

☐ No ☐ Yes If "Yes," ☐ Previously Reported
☐ Not Previously Reported10. PERFORMANCE SITE(S) (*Organizations and addresses*)

11a. PRINCIPAL INVESTIGATOR OR PROGRAM DIRECTOR (<i>Item 2a</i>)	TELEPHONE () FAX ()
11b. ADMINISTRATIVE OFFICIAL (<i>Item 5</i>) NAME	TELEPHONE () FAX ()
11c. NAME AND TITLE OF OFFICIAL SIGNING FOR APPLICANT ORGANIZATION (<i>Item 14</i>) NAME TITLE TELEPHONE () FAX () E-MAIL	

12. Corrections to Page 1 Face Page

13. PRINCIPAL INVESTIGATOR/PROGRAM DIRECTOR ASSURANCE: I certify that the statements herein are true, complete and accurate to the best of my knowledge. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. I agree to accept responsibility for the scientific conduct of the project and to provide the required progress reports if a grant is awarded as a result of this application.

SIGNATURE OF PI/PD NAMED IN 2a.
(*In ink. "Per" signature not acceptable.*)

DATE

14. APPLICANT ORGANIZATION CERTIFICATION AND ACCEPTANCE: I certify that the statements herein are true, complete and accurate to the best of my knowledge, and accept the obligation to comply with Public Health Services terms and conditions if a grant is awarded as a result of this application. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties.

SIGNATURE OF OFFICIAL NAMED IN 11c.
(*In ink. "Per" signature not acceptable.*)

DATE

DETAILED BUDGET FOR NEXT BUDGET PERIOD – DIRECT COSTS ONLY		FROM		THROUGH		GRANT NUMBER
PERSONNEL (Applicant organization only)		TYPE APPT. <i>(months)</i>	% EFFORT ON PROJ.	DOLLAR AMOUNT REQUESTED (omit cents)		
NAME	ROLE ON PROJECT			SALARY REQUESTED	FRINGE BENEFITS	TOTALS
	Principal Investigator					
SUBTOTALS →						
CONSULTANT COSTS						
EQUIPMENT <i>(Itemize)</i>						
SUPPLIES <i>(Itemize by category)</i>						
TRAVEL						
PATIENT CARE COSTS		INPATIENT				
		OUTPATIENT				
ALTERATIONS AND RENOVATIONS <i>(Itemize by category)</i>						
OTHER EXPENSES <i>(Itemize by category)</i>						
SUBTOTAL DIRECT COSTS FOR NEXT BUDGET PERIOD						\$
CONSORTIUM/CONTRACTUAL COSTS		DIRECT COSTS				
		FACILITIES AND ADMINISTRATON COSTS				
TOTAL DIRECT COSTS FOR NEXT PROJECT PERIOD <i>(Item 9a, Face Page)</i>						\$



BUDGET JUSTIFICATION

GRANT NUMBER

Provide a detailed budget justification for those line items and amounts that represent a significant change from that previously recommended. Use continuation pages if necessary.

CURRENT BUDGET PERIOD

FROM

THROUGH

Explain any estimated unobligated balance (including prior year carryover) that is greater than 25% of the current year's total budget.

BIOGRAPHICAL SKETCH

Provide the following information for the key personnel in the order listed for Form Page 2.
Follow this format for each person. **DO NOT EXCEED FOUR PAGES.**

NAME		POSITION TITLE	
EDUCATION/TRAINING <i>(Begin with baccalaureate or other initial professional education, such as nursing, and include postdoctoral training.)</i>			
INSTITUTION AND LOCATION	DEGREE <i>(if applicable)</i>	YEAR(s)	FIELD OF STUDY

NOTE: The Biographical Sketch may not exceed four pages. Items A and B may not exceed two of the four-page limit.

A. Positions and Honors. List in chronological order previous positions, concluding with your present position. List any honors. Include present membership on any Federal Government public advisory committee.

B. Selected peer-reviewed publications (in chronological order). Do not include publications submitted or in preparation.

C. Research Support. List selected ongoing or completed (during the last three years) research projects (federal and non-federal support). Begin with the projects that are most relevant to the research proposed in this application. Briefly indicate the overall goals of the projects and responsibilities of principal investigator identified above.

NAME OF INDIVIDUAL
ONGOING/COMPLETED

Project Number (Principal Investigator) Source Title of Project <i>(or Subproject)</i> The major goals of this project are...	Dates of Project (Entire Period of Support) Annual Direct Costs	Percent Effort
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Sample**ANDERSON, R.R.****ONGOING**

2 R01 HL 00000-13 Anderson (PI)	3/1/97 – 2/28/00	30%
NIH/NHLBI	\$186,529	
Chloride and Sodium Transport in Airway Epithelial Cells		

The major goals of this project are to define the biochemistry of chloride and sodium transport in airway epithelial cells and clone the gene(s) involved in transport.

5 R01 HL 00000-07 Baker (PI)	4/1/94 – 3/31/99	10%
NIH/NHLBI	\$122,717	
Ion Transport in Lungs		

The major goal of this project is to study chloride and sodium transport in normal and diseased lungs.

BIOGRAPHICAL SKETCH

Provide the following information for the key personnel in the order listed for Form Page 2.
Follow the sample format for each person. **DO NOT EXCEED FOUR PAGES.**

NAME		POSITION TITLE	
EDUCATION/TRAINING <i>(Begin with baccalaureate or other initial professional education, such as nursing, and include postdoctoral training.)</i>			
INSTITUTION AND LOCATION	DEGREE <i>(if applicable)</i>	YEAR(s)	FIELD OF STUDY

PROGRESS REPORT SUMMARY

GRANT NUMBER

PERIOD COVERED BY THIS REPORT

PRINCIPAL INVESTIGATOR OR PROGRAM DIRECTOR

FROM

THROUGH

APPLICANT ORGANIZATION

TITLE OF PROJECT (Repeat title shown in Item 1 on first page)

A. Human Subjects (Complete Item 6 on the Face Page)

Involvement of Human Subjects ☐ No Change Since Previous Submission ☐ Change

B. Vertebrate Animals (Complete Item 7 on the Face Page)

Use of Vertebrate Animals ☐ No Change Since Previous Submission ☐ Change

(SEE INSTRUCTIONS)

WOMEN AND MINORITY INCLUSION

See PHS 398 Instructions. Use Inclusion Enrollment Report Format Page and, if necessary, Targeted/Planned Enrollment Format Page.

CHECKLIST**1. PROGRAM INCOME (See instructions.)**

All applications must indicate whether program income is anticipated during the period(s) for which grant support is requested. If program income is anticipated, use the format below to reflect the amount and source(s).

Budget Period	Anticipated Amount	Source(s)

2. ASSURANCES/CERTIFICATIONS (See instructions.)

The following assurances/certifications are made and verified by the signature of the Official Signing for Applicant Organization on the Face Page of the application. Descriptions of individual assurances/ certifications are provided in Section III of the PHS 398. If unable to certify compliance, where applicable, provide an explanation and place it after this page.

•Human Subjects •Research Using Human Pluripotent Stem Cells
•Research on Transplantation of Human Fetal Tissue •Women and Minority Inclusion Policy •Inclusion of Children Policy •Vertebrate Animals

•Debarment and Suspension •Drug- Free Workplace (*applicable to new [Type 1] or revised [Type 1] applications only*); •Lobbying •Non-Delinquency on Federal Debt •Research Misconduct •Civil Rights (Form HHS 441 or HHS 690); •Handicapped Individuals (Form HHS 641 or HHS 690) •Sex Discrimination (Form HHS 639-A or HHS 690) •Age Discrimination (Form HHS 680 or HHS 690); •Recombinant DNA and Human Gene Transfer Research •Financial Conflict of Interest (except Phase I SBIR/STTR) •STTR ONLY: Certification of Research Institution Participation.

3. FACILITIES AND ADMINISTRATIVE (F&A) COSTS

Indicate the applicant organization's most recent F&A cost rate established with the appropriate DHHS Regional Office, or, in the case of for-profit organizations, the rate established with the appropriate PHS Agency Cost Advisory Office.

F&A costs will **not** be paid on construction grants, grants to Federal organizations, grants to individuals, and conference grants. Follow any additional instructions provided for Research Career Awards, Institutional National Research Service Awards, Small Business Innovation Research/Small Business Technology Transfer Grants, foreign grants, and specialized grant applications.

☐ DHHS Agreement dated: _____ ☐ No Facilities and Administrative Costs Requested.

☐ No DHHS Agreement, but rate established with _____ Date _____

CALCULATION*

Entire proposed budget period: Amount of base \$ _____ x Rate applied _____ % = F&A costs \$ _____

Add to total direct costs from Form Page 2 and enter new total on Face Page, Item 8b.

*Check appropriate box(es):

☐ Salary and wages base ☐ Modified total direct cost base ☐ Other base (*Explain*)
☐ Off-site, other special rate, or more than one rate involved (*Explain*)

Explanation (*Attach separate sheet, if necessary.*):

GRANT NUMBER

Place this form at the end of the signed original copy of the application. Do not duplicate.

All Key Personnel for the Current Budget Period

Name	Degree(s)	SSN	Role on Project (e.g. PI, Res. Assoc.)	Date of Birth (MM/DD/YY)	Annual % Effort

NEXT BUDGET PERIOD*(Follow instructions carefully)***FROM****THROUGH****GRANT NUMBER**

ITEMIZE DIRECT COSTS REQUESTED FOR NEXT BUDGET PERIOD

DOLLAR AMOUNT REQUESTED (omit cents)

PREDOCTORAL STIPENDS

No. Requested:

\$

POSTDOCTORAL STIPENDS *(Itemize)*

No. Requested:

\$

OTHER STIPENDS *(Specify)*

\$

TOTAL STIPENDS →

\$

TUITION, FEES, AND INSURANCE *(Itemize)*

\$

TRAINEE TRAVEL *(Describe)*

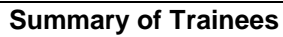
\$

TRAINEE RELATED EXPENSES

\$

TOTAL DIRECT COSTS FOR NEXT BUDGET PERIOD *(Also enter on Page 1, Item 8a)*

\$



Complete for trainees who have left the program or who have completed their training (during this reporting period)

Complete for all trainees for this reporting period.

Distribution of Trainees According to Category: Use the table on the “Inclusion Enrollment Report Format Page.”

NRSA Summary of Trainees
Additional Form Page 5

Targeted/Planned Enrollment Table**This report format should NOT be used for data collection from study participants.****Study Title:****Total Planned Enrollment:**

TARGETED/PLANNED ENROLLMENT: Number of Subjects			
Ethnic Category	Sex/Gender		
	Females	Males	Total
Hispanic or Latino			
Not Hispanic or Latino			
Ethnic Category Total of All Subjects*			
Racial Categories			
American Indian/Alaska Native			
Asian			
Native Hawaiian or Other Pacific Islander			
Black or African American			
White			
Racial Categories: Total of All Subjects *			

*The "Ethnic Category Total of All Subjects" must be equal to the "Racial Categories Total of All Subjects."

Inclusion Enrollment Report**This report format should NOT be used for data collection from study participants.****Study Title:** _____**Total Enrollment:** _____ **Protocol Number:** _____**Grant Number:** _____**PART A. TOTAL ENROLLMENT REPORT: Number of Subjects Enrolled to Date (Cumulative)
by Ethnicity and Race**

Ethnic Category	Sex/Gender			
	Females	Males	Unknown or Not Reported	Total
Hispanic or Latino				**
Not Hispanic or Latino				
Unknown (Individuals not reporting ethnicity)				
Ethnic Category: Total of All Subjects*				*
Racial Categories				
American Indian/Alaska Native				
Asian				
Native Hawaiian or Other Pacific Islander				
Black or African American				
White				
More than one race				
Unknown or not reported				
Racial Categories: Total of All Subjects*				*

PART B. HISPANIC ENROLLMENT REPORT: Number of Hispanics or Latinos Enrolled to Date (Cumulative)

Racial Categories	Females	Males	Unknown or Not Reported	Total
American Indian or Alaska Native				
Asian				
Native Hawaiian or Other Pacific Islander				
Black or African American				
White				
More Than One Race				
Unknown or not reported				
Racial Categories: Total of Hispanics or Latinos**				**

* These totals must agree.

** These totals must agree.